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Statement of Position

89-5

Financial Accounting and Reporting by Providers of Prepaid Health Care Services

May 8, 1989

Issued by
Accounting Standards Division

American Institute of
Certified Public Accountants

AICPA

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SUMMARY

This statement of position (SOP) provides guidance on applying generally accepted accounting principles in accounting and reporting by providers of prepaid health care services on health care costs, contract losses (premium deficiencies), stop-loss insurance (reinsurance), and contract acquisition costs. Briefly, the statement recommends the following:

1. Health care costs should be accrued as the services are rendered, including estimates of the costs incurred but not yet reported to the plan. Furthermore, if a provider is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs to be incurred of such services should also be accrued currently. Costs that will be incurred after a contract is terminated, such as guaranteed salaries, rent, and depreciation; net of any related anticipated revenues, should be accrued when it is determined that a contract with a sponsoring employer or other group will be terminated. Amounts payable to hospitals, physicians, or other health care providers under risk-retention, bonus, or similar programs should be accrued during the contract period based on relevant factors, such as experience to date.

2. A loss should be recognized when it is probable that expected future health care costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts.

3. Stop-loss insurance premiums should be included in reported health care costs. Stop-loss insurance recoveries should be reported as a reduction of the related health care costs. Receivables representing amounts recoverable from insurers should be reported as assets, reduced by appropriate valuation allowances.

4. Contract acquisition costs should be expensed as incurred.

The provisions of this statement are effective for fiscal years beginning on or after June 15, 1989, with earlier application encouraged. Accounting changes adopted to conform to the provisions of this statement should be applied retroactively, if practicable.

Financial Accounting and Reporting by Providers of Prepaid Health Care Services

Introduction

1. The rapidly rising cost of health care services in recent years has led to an increased interest and acceptance of prepaid health care plans. These plans serve as an alternative system for the delivery and financing of health care services. Many employers now offer employees a choice between traditional insurance coverage and prepaid health care plans.

2. As a result of the rapid growth of prepaid health care plans, diverse practices have developed in accounting for and reporting health care costs, contract losses (premium deficiencies), stop-loss insurance (reinsurance), and contract acquisition costs of providers of prepaid health care services. This statement has been prepared as a basis for reducing the existing diversity of accounting and reporting practices in these areas. The appendix describes the operations of health maintenance organizations (HMOs), which are the most common form of organization providing prepaid health care services.

Scope

3. This statement applies to providers of prepaid health care services as defined in paragraph 4.

Definitions

4. The following terms are used in this statement:

Acquisition costs. Marketing costs that are (a) directly related to the acquisition of specific subscriber contracts and member enrollment and (b) incremental to general marketing activities.

Associated entity. An individual practice association, a medical group, or a similar entity that contracts with a prepaid health care provider to provide health care services.

Capitation fee. A fixed amount per member that is paid periodically (usually monthly) to a provider as compensation for providing defined health care services according to the contract provisions. The fee is set by contract between the provider of services and the prepaid health care provider. These contracts are generally with medical groups or individual practice associations, but may also be with hospitals and other providers. The capitation fee may be actuarially determined on the basis of expected costs to be incurred.

Contract period. The period for which premium rates are fixed by contract (typically one year).

Copayment. A payment required to be made by a member to a provider when health care services are rendered. Examples of typical copayments include fixed charges for each physician office visit, prescriptions, or certain elective surgical procedures.

Date of initial service. The date that a prepaid health care provider identifies that a member has an illness or shows symptoms requiring the member to obtain future health care services.

Health care costs. All costs of prepaid health care providers other than general and administrative, selling, maintenance, marketing and interest.

Health maintenance organizations (HMOs). A generic group of medical care entities organized to provide defined health care services to members in return for fixed, periodic premiums (usually paid monthly) paid in advance.

Incurred but not reported (IBNR) costs. Costs associated with health care services incurred during a financial reporting period but not reported to the prepaid health care provider until after the financial reporting date.

Individual practice association (IPA). A partnership, association, corporation, or other legal entity organized to provide or arrange for the delivery of health care services to members of a prepaid health care plan and nonmember patients. In return, the IPA receives either a capitation fee or a specified fee based on the type of service rendered.

Maintenance costs. Costs of maintaining enrollment records and processing collections and payments.

Medical group. An association of physicians and other licensed health care professionals organized on a group basis to practice medicine.

Member. An individual who is enrolled as a subscriber or as an eligible dependent of a subscriber in a prepaid health care plan.

Preferred provider organization (PPO). An organization that contracts with providers to deliver health care services for a negotiated fee based on the level of utilization. There are financial incentives to subscribers to use the contracting providers. PPOs generally operate as brokers and normally do not accept the transfer of financial risk.

Premium (subscriber fee). The consideration paid to a prepaid health care provider for providing contract coverage. Premiums are typically established on an individual, two-party, or family basis and paid monthly.

Premium period. The period to which a premium payment applies (generally one month) that entitles a member to health care services according to the contract provisions.

Prepaid health care plan. An arrangement between a health care provider and a sponsoring organization, such as an employer, specifying the payment of a fixed sum or fixed amount per member in advance for services to be delivered by the provider in accordance with the terms of the arrangement. The arrangement (plan) may cover a wide range of health care services (for example, comprehensive medical plans) or a specialized aspect of health care service (for example, dental and eye care plans).

Prepaid health care services. Any form of health care service provided to a member in exchange for a scheduled payment (or payments) established before care is provided—regardless of the level of service subsequently provided.

Providers of prepaid health care services (prepaid health care providers). Entities that provide or arrange for the delivery of health care services in accordance with the terms and provisions of a prepaid health care plan. Providers assume the financial risk of the cost of delivering health care services in excess of preestablished fixed premiums. However, some or all of this financial risk may be contractually transferred to other providers or by purchasing stop-loss insurance. The most common form of organization providing prepaid health care services is the health maintenance organization, which is described in paragraphs 6 to 18 and the appendix of this statement. Other providers of prepaid health care services may include comprehensive medical plans, physicians groups (for example, independent practice associations), and hospitals.

Stop-loss insurance. A contract in which an insurance company agrees to indemnify providers against certain health care costs incurred by members. (The term "reinsurance" is used extensively in the prepaid health care industry but generally refers to stop-loss insurance.)

Subscriber. The person who is responsible for payment of premiums or whose employment is the basis for eligibility for membership in a prepaid health care plan.

Background

5. Paragraphs 6 to 18 provide a general description of HMOs. A more detailed description is provided in the appendix of this statement.

6. An HMO is a formally organized health care system that combines delivery and financing functions. An HMO provides its members with defined health care services in return for fixed periodic premiums (usually monthly) paid in advance.

7. Many HMOs are not-for-profit entities, but there is a growing trend to establish for-profit HMOs. The Public Health Services Act and the regulations of the United States Department of Health and Human Services specify the features of, and the reporting requirements for, federally qualified HMOs. However, HMOs are not required to be federally qualified. Most HMOs are also regulated by state agencies—typically the department of insurance, the health department, or the department of corporations.

8. There are four basic kinds of HMOs. They differ in the type of relationship they have with physicians and members, as follows:

a. *Staff HMO.* The HMO employs and compensates the physicians. All premiums and other revenues accrue to the HMO.

b. *Group HMO.* Physicians practice in a centralized center or clinic usually provided by the HMO. The physicians are organized as a partnership, professional corporation, or other association, which contracts to provide health care services to members of the HMO. The HMO compensates the medical group.

c. *Individual practice association (IPA) HMO.* Patients are treated in the physicians' offices. The HMO may contract with a physician group that, in turn, contracts with individual physicians. Alternatively, the HMO may contract directly with individual physicians. Medical expenses of IPAs tend to be variable, whereas staff and group HMOs tend to have high percentages of fixed costs.

d. *Network HMO.* An HMO contracts with various physician groups that are organized in single-specialty or multi-specialty group practices to provide defined health care services to members over the contract term. Unlike the other kinds of HMOs, network HMOs are not recognized for federal qualification.

9. An HMO usually provides financial incentives to physicians to control health care costs. Physicians or other health care providers compensated on a capitation basis have incentives to keep total costs below the fees received. Physicians may receive bonuses if utilization of hospital and outpatient services by HMO members is lower than expected. In an IPA HMO, a physician usually receives a percentage of the standard fee charged by the IPA; the remaining amount is retained by the IPA in a risk pool for later distribution based on cost experience.

10. An HMO's contractual arrangements with individual physicians, physician groups, IPAs, or hospitals specify which entity bears the financial risk for adverse cost experience. An HMO may fix its costs—and thus limit its financial risk—by compensating health care providers on a capitation basis, rather than a fee-for-service basis. Likewise, an IPA may limit its financial risk by contracting with physicians or hospitals on a capitation basis. In staff and group HMOs, costs of physician and outpatient services are relatively fixed, because the physicians and support personnel are salaried employees. Consequently, a substantial portion of a staff or group HMO's total costs does not vary with the amount of services provided. Incremental costs primarily consist of costs of specialized services bought from other providers on a fee-for-service basis.

11. Premium rates typically are set by HMOs for contract periods of one year and are designed to cover the anticipated total costs of services to be rendered to members during those periods, as well as provide for margins for profit and adverse experience. Premiums are often community-rated, that is, one premium rate schedule is established for all members in a particular geographic area.

12. Under a community-rating method, each member is charged the same premium for the same health care benefits. This method distributes health care costs equally over the community of subscribers rather than charging the unhealthy more than the healthy. The premium revenue is expected to cover the health care costs of the entire membership.

13. Alternatively, premiums under an experience-rating method are based on the actual or anticipated health care costs of each contract. Member groups that incur higher health care costs in relation to other member groups pay higher premiums.

14. A fundamental difference between community rating and experience rating relates to the particular base used for setting premium rates. In a community-rated HMO, the community is generally understood to mean the HMO's entire membership. Alternatively, in an experience-rated HMO, members covered by each contract constitute a separate population base.

15. Premiums are generally required to be paid monthly in advance. Subscribers can cancel HMO contracts at the end of any month. An HMO generally cannot cancel contracts or increase premium rates during the contract periods.

16. Premiums are reported as revenue in the month that members are entitled to health care services. Premiums collected in advance generally are reported as deferred income.

17. An HMO undertakes to provide health care services to members during the contract period and normally does not provide health care services if the premiums are not paid. HMOs generally do not exclude preexisting conditions.

18. In certain circumstances, an HMO may continue providing service to a member hospitalized at the end of the contract period and until the member is discharged from the hospital (or until medical care ceases) due to contractual obligations, state regulatory requirements, or management policy. The HMO also may provide for an extension of coverage for specific items such as pregnancy.

Accounting for Health Care Costs

Discussion

19. The primary accounting issue is when to recognize the cost of prepaid health care services as expenses, either (a) as those services are rendered or (b) on the date of initial service, thereby requiring the current accrual of future costs of health care services expected to be provided to members for illnesses or conditions requiring continuing medical treatment.

Present Practices

20. There is considerable diversity in accounting for the costs of prepaid health care services. Providers may presently account for such costs (a) on the cash basis (paragraph 21), (b) when the costs are reported to the provider (paragraph 21), (c) when the services are rendered, including an estimate of incurred but not reported (IBNR) costs (paragraph 22), or (d) based on the estimated future cost of services to be provided to hospitalized members (paragraphs 23-29). In addition, some have proposed that providers also accrue at the date of initial service the estimated cost of future services to be provided to non-hospitalized members (related to a particular illness or accident) over the remainder of the contract term or in all future periods (paragraphs 24-29).

Views on the Issues

21. *Cash Basis and As-Reported Basis.* Accrual accounting is the prescribed basis of accounting for financial statements prepared in conformity with generally accepted accounting principles (GAAP). Therefore, the recognition of the costs of prepaid health care services as expenses solely in the period paid or reported to the provider does not conform with GAAP.

22. *Accrual of Health Care Costs as Services are Rendered.* Some believe that health care costs should be accrued as the services are rendered and, therefore, should include an estimate of IBNR costs. This method is consistent with the generally accepted practice of accruing expenses as incurred and matching related revenues and expenses (monthly premiums would be matched against monthly expenses). Supporters of this approach believe that monthly premiums designed to cover monthly expenses should not be matched against a combination of current and future expenses, which would be the case if costs were accrued at the date of initial service. They believe that regardless of whether a provider has an obligation to provide services beyond the period that premiums are paid, it should not have to accrue currently a liability for future services. Finally, they believe that a prepaid health care plan is predicated on a group basis; therefore, future costs associated with particular individuals should not be designated for special accounting treatment as described in the following paragraphs.

23. *Accrual of Health Care Costs According to Contractual Liability.* Some believe that in addition to accruing costs as described in paragraph 22, a provider should accrue any estimated future health care costs that it is obligated to provide beyond the period for which the premium has been paid (premium period). For example, some providers accrue estimated future health care costs as of the date a member is admitted to a hospital. They argue that, under some contracts, a provider must continue to provide services to a hospitalized member until the member is discharged regardless of whether the contract expires or premiums are continually paid. They believe, therefore, that the expense is incurred when the member is hospitalized because the provider cannot later avoid the costs associated with that hospitalization.

24. *Accrual of Health Care Costs at the Date of Initial Service.* Some believe that health care costs should be accrued at the date of initial service. This would require the accrual of estimated future costs associated with individual members requiring long-term treatment. Supporters of this approach believe it is consistent with Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards (SFAS) No. 5, *Accounting for Contingencies*, requiring the accrual of liabilities when the amounts are reasonably estimable. They also believe that the obligation to provide future services meets the definition of liabilities in FASB Statement of Financial Accounting Concepts (SFAC) No. 6, *Elements of Financial Statements*. Finally, they believe this method is consistent with GAAP for accident and health insurance policies and that the service provided by prepaid health care providers is substantially the same as the service provided by insurance companies.

25. Some supporters of this approach believe that the costs to be accrued as of the date of initial service only relate to services to be provided during the remainder of the contract period. They believe that providers are obligated only to provide services to the end of the contract period. Therefore, costs that may be incurred beyond that date should not be accrued currently because the contract may not be renewed or premium rates may be significantly changed.

26. Others believe that the costs to be accrued at the date of initial service should relate to all future services expected to be provided to the member. They believe it is reasonable to assume that members with significant health problems will continue to renew their contracts with the providers. Therefore, it is probable that the costs will be incurred, even in subsequent contract periods.

27. Opponents of the methods discussed in paragraphs 23 to 26 believe that prepaid health care providers currently have no liability for future services. They believe that the event resulting in a liability to the provider is the rendering of health care services, not the occurrence of an accident or illness during the contract or premium period. A prepaid health care provider undertakes to provide health care services for a particular period without regard to the timing of the accident or illness that leads to the service. They believe that a liability should not be accrued until the services are rendered.

28. Opponents of the methods discussed in paragraphs 23 to 26 also believe the methods could result in a mismatching of reported revenues and expenses, because they would recognize a relatively greater amount of expense in the earlier part of the contract period, whereas the methods discussed in paragraph 22 would result in a more level recognition of expense over the period. In addition, the methods described in paragraphs 23 to 26 would require a significantly greater degree of estimation, which could adversely affect the cost of preparing financial statements and the usefulness of the information. Furthermore, the method described in paragraph 26 might require consideration of factors such as estimated future premiums and the time value of money, which would make the financial statements more subjective.

29. Some of those who believe that the estimated costs of future services should be accrued currently believe that such costs should include only the incremental costs to be incurred as a result of the health care services to be provided. Costs such as physicians' salaries and capitation fees or other costs related to provider-owned hospitals or other inpatient facilities that will not increase as a result of the amount of services to be provided should not be accrued currently. They believe that the accrual should relate to identifiable incremental costs of providing health care services and not to fixed period costs. Others believe that all costs incurred in providing the services should be accrued, because these costs are directly related to the provider's obligation. They would also accrue an allocable portion of the nonincremental ("fixed") costs.

Conclusion

30. Health care costs should be accrued as the services are rendered, including estimates of the costs of services rendered but not yet reported. Furthermore, if a provider of prepaid health care services

is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs to be incurred of such services should also be accrued currently. (See the exhibit on the following page.) Costs that will be incurred after a contract is terminated, such as guaranteed salaries, rent, and depreciation, net of any related anticipated revenues, should be accrued when it is determined that a contract with a sponsoring employer or other group will be terminated.

31. Amounts payable to hospitals, physicians, or other health care providers under risk-retention, bonus, or similar programs should be accrued during the contract period based on relevant factors, such as experience to date.

32. The basis for accruing health care costs and significant business and contractual arrangements with hospitals, physicians, and other associated entities should be disclosed in the notes to the financial statements.

Implementation Aid—Accounting for Health Care Costs

The following illustrates the conclusions in the first and second sentences of paragraph 30. The illustrations demonstrate accounting for providers of prepaid health care services for two variations of contractual terms; however, other variations may exist.

Assumptions:

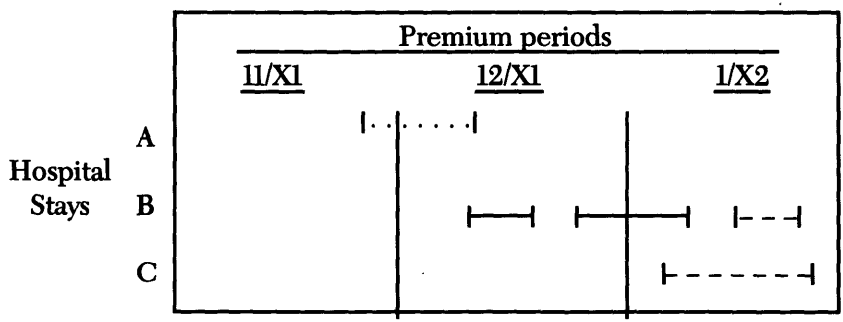
a. Patients A, B, and C are referred to Community Hospital by the prepaid health care provider:

Patient	*Reason for Hospital Stay*	*Period(s) of Hospital Stay*
A	Short-term illness	November 26, 19X1–December 6, 19X1
B	Long-term illness	December 5, 19X1–December 14, 19X1
		December 19, 19X1–January 10, 19X2
		January 15, 19X2–January 21, 19X2
C	Long-term illness	January 7, 19X2–January 28, 19X2

b. Reporting date is 12/31/X1

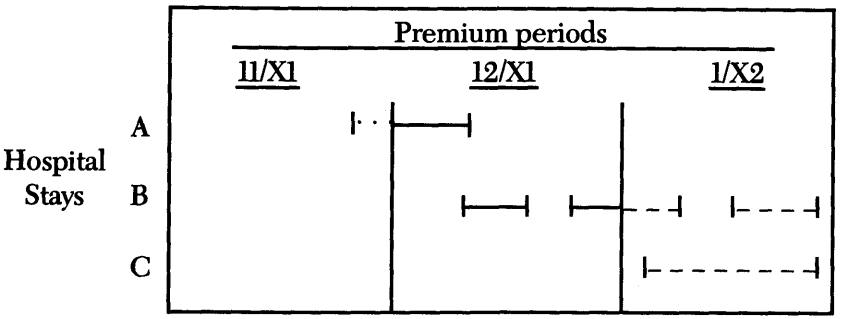
c. Contract period is July 1, 19X1, through June 30, 19X2.

Illustration 1
Contract Provides Coverage for Hospital Stays That Begin During the Premium Period



Note: . . . . cost of services to be recorded in premium period 11/X1.
____ cost of services to be recorded in premium period 12/X1.
_ _ _ cost of services to be recorded in premium period 1/X2.

Illustration 2
Contract Provides Coverage for Days of a Hospital Stay Within a Premium Period



Note: . . . . cost of services to be recorded in premium period 11/X1.
____ cost of services to be recorded in premium period 12/X1.
_ _ _ cost of services to be recorded in premium period 1/X2.

Accounting for Loss Contracts

Discussion

33. A prepaid health care provider enters into contracts to provide members with specified health care services for specified periods, in return for fixed periodic premiums for fixed periods. Associated entities such as medical groups and IPAs may enter into similar contracts with prepaid health care providers in which they agree to deliver identified health care services to the providers' members for specified periods in return for fixed capitation fees. Prepaid health care contracts can be terminated only by the action or inaction of the subscriber, for example, not paying premiums. The premium revenue is expected to cover health care costs and other costs over the terms of the contracts. Only in unusual circumstances would a provider be able to increase premiums on contracts in force to cover expected losses. A provider may be able to control or reduce future health care delivery costs to avoid anticipated losses, but the ability to avoid losses under existing contracts may be difficult to measure or demonstrate.

34. Expected losses on existing contracts are currently recognized in other industries, such as construction and insurance, whose premium deficiencies are recorded when anticipated claims and other costs are

expected to exceed unearned premiums. Paragraph 96 of SFAS No. 5 states the following:

> . . . this Statement does not prohibit (and, in fact, requires) accrual of a *net* loss (that is, a loss in excess of deferred premiums) that probably will be incurred on insurance policies that are in force, provided that the loss can be reasonably estimated, just as accrual of net losses on long-term construction-type contracts is required.

Current accounting and financial reporting literature does not specifically address the question of whether prepaid health care providers should accrue anticipated losses on health care contracts in force currently.

Present Practices

35. Losses are generally not recognized when anticipated costs are expected to exceed anticipated revenues during the unexpired terms of the existing contracts.

Views on the Issues

36. Some believe that anticipated losses on contracts should not be accrued currently. They maintain that health care costs incurred in subsequent periods are not costs of the current period because the events resulting in anticipated health care costs—the rendering of service—have not occurred. They believe that providers are usually obligated to provide services only as long as premiums are paid. They believe that reporting anticipated losses currently involves the assumption that the contract will continue and that future premiums will be paid, but these events relate to a future period. They also believe that providers do not have significant liabilities for unearned premiums as insurance companies do, because premiums are generally collected monthly to cover the cost of treatment during that month. The premium deficiency concept of insurance accounting therefore does not apply to prepaid health care providers.

37. Others believe that losses should be recognized when the anticipated future contract premiums are less than estimated future health care costs and maintenance expenses. They note that the basic agreement between a provider and the member fixes the premium rate for the entire contract period, and the contract can be terminated only by the member. Consequently, the provider's ability to avoid incurring anticipated future losses is limited. They believe that the

criteria for accruing a liability in conformity with SFAS No. 5 have been met when it is probable that projected health care costs and maintenance expenses will exceed anticipated premium revenue to be received over the remaining terms of existing contracts.

38. Some believe that losses should be recognized only when incremental health care costs and maintenance expenses exceed anticipated future premiums during the unexpired terms of groups of existing contracts. Fixed period costs, such as staff physicians' salaries and costs related to provider-owned facilities or other indirect costs that will not change as a result of the contract, should not be considered in computing the loss. Supporters of this approach believe that fixed period costs should never be considered in reporting losses. They believe that a loss should be recorded only when the provider is financially worse off as a result of the contract. Others believe that all health care costs and maintenance expenses should be considered in determining whether a loss has been incurred, including fixed costs that are not directly associated with the group of contracts resulting in the loss.

39. Some who argue that contract losses should be recognized currently believe that they should be determined on an aggregate basis for all contracts in force at the end of each period. They maintain that the losses should not be determined contract by contract, because the services provided under the contracts are similar, and losses on individual contracts are likely to be recovered from profits on other contracts.

40. Others believe that to determine the existence of a loss, contracts should be grouped on the basis of common characteristics such as geographic location or family or employer composition used to establish community premium rates (community rating). Federally qualified prepaid health care providers generally use community rating, and many local statutes require its use.

Conclusion

41. A loss should be recognized when it is probable that expected future health care costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts. The estimated future health care costs and maintenance costs to be considered in determining whether a loss has been incurred should include fixed and variable,

direct and allocable indirect costs. Contracts should be grouped in a manner consistent with the provider's method of establishing premium rates, for example, by community-rating practices, geographical area, or statutory requirements, to determine whether a loss has been incurred.

Accounting for Stop-Loss Insurance

Discussion

42. In stop-loss insurance, prepaid health care providers transfer portions of their financial risks to insurance companies. A provider typically contracts with an insurance company to recover health care costs in excess of stated amounts during the contract periods.

43. Current accounting and financial reporting literature does not address accounting for stop-loss insurance by prepaid health care providers. Paragraphs 38 to 40 and 60f of SFAS No. 60, *Accounting and Reporting by Insurance Enterprises*, describe the reporting requirements for reinsurance transactions of insurance enterprises.

Present Practices

44. In their income statements, some providers report stop-loss insurance costs as operating expenses, whereas others report them as reductions of gross premium revenues. Some providers report amounts recovered or recoverable from insurers as additional revenue, while others reduce health care costs by these amounts.

45. In their balance sheets, some providers report amounts recoverable from insurers as reductions of accrued health care costs. Others report all amounts recoverable from insurers as assets, subject to appropriate valuation allowances.

Views on the Issues

46. Prepaid health care providers generally view stop-loss insurance premiums as operating expenses and normal and recurring business transactions incurred to provide protection from excessive loss. In turn, they view stop-loss insurance recoveries as additional revenue. These views are consistent with uniform reporting practices adopted by provider regulators. Others consider the insurers to be providing portions of the members' coverage for premiums. Consequently, they

view a portion of the gross premiums collected as due to the insurer and accordingly, the stop-loss premiums as a deduction to arrive at net premium revenue reported. Because the insurer is considered to have assumed a portion of the risk and to be responsible for that portion of the loss, reported health care costs are reduced by the amounts recovered or recoverable from insurers.

47. Some believe that amounts recoverable from insurers for unpaid losses should be applied to reduce reported health care costs because they believe that stop-loss insurance is inextricably linked to the basic contract.

48. Others believe that all amounts recoverable from insurers should be reported as assets. They base their views on GAAP, which generally prohibits the offsetting of receivables and payables to unrelated parties.

Conclusion

49. Stop-loss insurance premiums should be included in reported health care costs. Stop-loss insurance recoveries should be reported as reductions of related health care costs. Receivables representing amounts recoverable from insurers should be reported as assets, reduced by appropriate valuation allowances. In addition, the nature, amounts, and effects of significant stop-loss insurance contracts should be disclosed.

Accounting for Contract Acquisition Costs

Discussion

50. Providers of prepaid health care services incur costs in connection with writing new contracts and obtaining premiums. The accounting issue is whether—and the extent to which—such costs should be deferred. Currently, insurance companies defer certain acquisition costs and amortize them as the related revenues are earned.

Present Practices

51. Many prepaid health care providers incur costs that vary with and are primarily related to the acquisition of subscriber contracts and member enrollment. These costs, sometimes referred to as marketing costs, consist mainly of commissions paid to agents or brokers

and incentive compensation based on new enrollments. Commissions and incentive compensation may be paid when the contracts are written, at later dates, or over the terms of the contracts as premiums are received. Some providers incur additional costs directly related to the acquisition of specific contracts such as the costs of specialized brochures, marketing, and advertising. Providers also incur costs that are related to the acquisition of new members but that do not relate to specific contracts. These costs include salaries of the marketing director and staff, general marketing brochures, general advertising, and promotion expenses. Currently, most providers report all acquisition costs as expenses when incurred regardless of whether they vary with or are primarily related to the acquisition of business.

Views on the Issues

52. Some favor continuing the current practice of expensing all acquisition costs as incurred. They believe that such costs may not provide discernible and measurable future benefits and, therefore, should not be reported as assets. Furthermore, they believe that the costs of identifying acquisition costs for reporting as assets on a group or specific contract basis would outweigh any benefits to be derived from deferring such costs. They also believe that other industries report marketing costs as expenses when incurred and that reporting such costs as assets might create diverse reporting under similar circumstances.

53. Others favor deferring acquisition costs such as commissions, incentive compensation based on production, and incremental marketing costs directly related to a successful campaign to obtain specific contracts. Such costs would be charged to expense over the initial contract term in proportion to the premium revenue recognized. They believe that only incremental costs directly related to the acquisition of business should be deferred. They cite the principle in paragraph 157 of APB Statement No. 4, *Basic Concepts and Accounting Principles Underlying Financial Statements of Business Enterprises*, which states that "some costs are recognized as expenses on the basis of a presumed direct association with specific revenue. . . . Recognizing them as expenses accompanies recognition of the revenues."

Conclusion

54. Although there is theoretical support for deferring certain acquisition costs, acquisition costs of providers of prepaid health care services should be expensed as incurred.

Effective Date and Transition

55. This statement is effective for fiscal years beginning on or after June 15, 1989, with earlier application encouraged. Accounting changes adopted to conform to the provisions of this statement should be applied retroactively, if practicable. In the year during which this statement is first applied, the financial statements should disclose the nature of any restatement and its effect on income before extraordinary items, net income, and related per share amounts for each year restated.

56. If retroactive restatement of all years presented is not practicable, the financial statements presented should be restated for as many consecutive years as practicable. The cumulative effect of applying the statement should be included in determining net income of the earliest year presented. If it is not practicable to restate any prior year, the cumulative effect should be included in net income in the year in which the statement is first applied, in conformity with paragraph 20 APB Opinion 20, *Accounting Changes*.

APPENDIX

Description of Health Maintenance Organizations

Overview

A-1. A health maintenance organization (HMO) is a formally organized system of health care that combines the functions of delivery and financing. The HMO contracts with subscribers to provide comprehensive health care services in return for a fixed periodic (generally monthly) premium for a fixed period (generally one year).

A-2. HMOs are categorized by federal regulation as one of three types: staff, group, or individual practice association. Other types are also possible. Regardless of the type, the HMO is the umbrella organization that administers the operation of the plan, monitors the use of services, and interacts with the medical staff and other personnel as well as with the enrolled members. The HMO services a geographic area in which members are able to obtain services from the organized health care delivery service.

A-3. Many HMOs are not-for-profit entities. The following types of organizations, with and without federal financial assistance, have sponsored the development of HMOs: consumer groups, employees, labor unions, medical schools, insurance carriers, Blue Cross/Blue Shield service plans, medical groups, partnerships and professional corporations, independent community hospitals, for-profit and not-for-profit hospital chains, cities, medical societies, neighborhood health centers, and business coalitions.

A-4. HMOs exist in a regulated environment. They are not required to be federally qualified (that is, an entity that has been found by the Secretary of the Department of Health and Human Services to meet the applicable requirements of Title XIII of the Public Health Service Act and its regulations), but there are two significant advantages to qualification:

a. Federally qualified HMOs benefit from the legislative mandate of "mandatory dual choice." This provision requires most employers in the HMO's service area to include the option of an IPA and a group model HMO, if available, in any of their health care benefit plans.

b. Many employers believe that federal qualification is a prerequisite for including the HMO in their health care benefit plans. Federally qualified HMOs must comply with complex federal reporting requirements. Most HMOs are under the control of state agencies—typically the department of insurance or the department of corporations. Those departments impose certain operating requirements as a condition for continued licensure, qualification, or contractual relationships.

A-5. Enrollment in HMOs is recruited from the following specific groups as defined by principal sources of payment for medical care: large group employers, public employers, Medicaid and Medicare beneficiaries, small group aggregates, and individuals.

A-6. The services that HMOs offer vary. To be federally qualified, the HMO must include the basic health services required by the HMO Act of 1973, and the services must be provided to members without restrictions on time and cost, except for certain prescribed limitations (for example, maximum visits for mental health and copayments). The basic health services include (a) diagnostic and therapeutic services, (b) inpatient hospital services, (c) short-term rehabilitation, (d) emergency health care services, (e) services for abuse of or addiction to alcohol or drugs, (f) diagnostic laboratory and diagnostic and therapeutic radiological services, (g) home health services, and (h) preventive health services, such as prescription drugs, dental care, and vision care.

A-7. A member may have health care coverage under more than one health care plan or insurer. In those cases, responsibility for the payment of costs is allocated among the parties, based on provisions of law, regulation, or contract in a process called coordination of benefits.

A-8. Prepaid periodic premiums are designed to cover the costs of health care services, the costs of acquiring and enrolling members, and general and administrative expenses, as well as to provide a margin for profit and adverse experience. To remain competitive, some HMOs require member copayments to supplement the premiums. Typical copayments range from two dollars to five dollars for an office visit to a physician.

HMO Models

A-9. There are four basic HMO models. They are differentiated by the type of relationship that has been established between the physicians who deliver the services to members and the legal corporate entity (the HMO).

A-10. *Staff Model.* Physicians are organized as employees who devote their practices to the HMO. All revenues, including premiums and fee-for-service revenues, accrue to the HMO. Physicians are compensated by an arrangement other than fee-for-service, such as salary or retainer. The physicians generally practice as a group in a centralized facility and share common support personnel, medical records, and equipment. This model is also referred to as a "closed panel," because enrollees may select only from among these physicians to receive contracted benefits.

A-11. *Group Model.* Physicians and other licensed health care professionals are organized as a partnership, a professional corporation, or

another association that executes an agreement or contract with one or more HMOs. The physicians and health care professionals are not salaried employees or "staff" of the HMO, but this model is still considered a "closed panel." As their principal professional activity, they engage in a coordinated practice; as a group, they devote a significant amount of their aggregate activity to the delivery of health care service to HMO members. Like the staff model, members of the medical group share records, equipment, and professional, technical, and administrative staff. The HMO compensates the medical group at a negotiated rate, which is then distributed to the physician group members according to a prearranged schedule.

A-12. *Individual Practice Association Model.* An IPA is a partnership, association, corporation, or other legal entity that delivers, or arranges for the delivery of health care services in accordance with a contract with an HMO. The IPA accepts a fee (generally a predetermined capitation fee) and a corresponding obligation to provide identified health care services over the contract term. To provide the services, the IPA enters into service and compensation arrangements with health care professionals. This model differs from the previous two in that physicians continue in individual or group practice and maintain their existing offices. Many IPAs originally were sponsored by local medical societies as "foundations for medical care," and all or most of the physicians in an area usually were invited to participate. Thus, the IPA became associated with the concept of an "open panel" practice. Membership in an IPA does not limit a physician's practice to treatment of HMO enrollees.

A-13. The HMO may compensate the IPA at a negotiated per capita rate for enrolled members. Likewise, the IPA's compensation arrangement with member physicians may be at a negotiated rate per capita, on a flat retainer fee, or on a fee-for-service basis. To reconcile fee-for-service compensation to physicians with the fixed prepaid revenue the IPA receives from the HMO, the physician often agrees to a discounted fee schedule or an acceptance of a degree of financial risk. That is, the physician will agree to accept a percentage of his or her regular fee or a discounted fee with the balance held in reserve. At year end, if the use of the health care services has been within the projected limits, the physicians may receive the balance of their claims after provision for contingencies. If premiums are inadequate, the physician may agree to accept a pro rata decrease in fees and may even be liable for inappropriate hospital costs. The HMO may also compensate physicians directly.

A-14. *Network Model.* As with the group model HMO, physicians and other licensed health care professionals are organized as partnerships, professional corporations, or other associations for the group practice of medicine. These group practices may be multi-specialty or single-specialty practices. The HMO contracts with various group practices to provide

identified health care services over the contract term. As compensation for providing these services, the groups receive a fixed capitation fee per member per period, regardless of the number of visits the members make to the groups. This income is then distributed to the individual physician-group members according to a prearranged schedule. Unlike other models, a network model is not a recognized category for purposes of federal qualification. Network models applying for federal qualification have generally been categorized as IPAs when qualified. However, network model characteristics are generally similar to the group model characteristics.

Cost and Use Control

A-15. To control health care costs and the use of services, an HMO generally assigns each member, or allows a member to choose, a primary care physician. This physician typically authorizes all services, including hospitalization and referral to member specialists and nonmember physicians. Under a capitation system, the physician has an incentive to maintain costs at or below the capitation fee received. Most group models are on a capitation basis. Additionally, financial incentives are usually provided to physicians to reduce health care costs. Contracts may provide for a sharing of any savings realized from lower-than-expected use of hospital and outpatient services. In the IPA model, the physician usually receives a percentage of the agreed fee, with the remaining amount held by the IPA in a risk pool. If usage of hospital and outpatient facilities for the year is as expected, the physicians receive the remaining amount. If usage is lower than expected, the physicians may share in a risk pool; if higher than expected, they receive a lower percentage of the billed fee. In addition, the IPA may share in a hospital risk pool, if any, and the physicians would share in any savings realized as a result of lower hospital use. Furthermore, an HMO may control use through medical review boards, prehospitalization certification, or prereferral screening.

Hospitalization Services

A-16. A few HMOs own and operate hospitals or other inpatient facilities. However, inpatient hospitalization, except for bona fide emergency care services, is usually provided by hospitals that have contracted with the HMO. The relationship between hospitals and HMOs may be informal, with the hospital granting admitting privileges to a plan's physicians, or there may be a formal contract under which the hospital guarantees the availability of a predetermined number of beds, regardless of whether the beds are actually used. Several financial arrangements are possible. The HMO may pay the hospital a periodic amount, similar to a retainer, for a given number of beds. The HMO may make a prospective payment with or without retrospective adjustment at the end of the accounting period; or it may retrospectively reimburse the hospital. In the last two cases, the HMO

pays according to a fee-for-service arrangement, which may be either full or discounted costs and charges. In addition, HMOs may compensate hospitals based on costs incurred or on a specific fee basis.

Risk Evaluation

A-17. An HMO's contractual arrangements with IPAs, groups, and hospitals determine which entity bears the financial risk for adverse experience if actual health care costs exceed the premium or capitation fee received and the extent of that risk. For example, the HMO may continue to bear the risk of adverse experience for hospitalization and related inpatient charges, but it may shift the risk for physician and outpatient services to the group or IPA by a capitation-compensation arrangement. Drug costs may be retained by the HMO or may be capitated to the medical group or IPA. In the latter situation, the extent of risk borne by the group or IPA depends primarily on the physician compensation arrangement. Compensation on a fixed-salary basis, provided enrollment is sufficient to cover those salaries, generally limits risk to the amount of outside costs incurred for specialists who are not members of the group. Likewise, compensation of IPA physicians on a capitation basis limits the IPA's risk. If the IPA or group provides for fee-for-service or incentive compensation, respectively, its risk exposure is greater because its claims may exceed capitation fees, and the IPA may be unable to lower the fees paid to physicians. Additionally, the IPA may not be able to retain physicians since they have the option of withdrawing from the IPA.

A-18. A few HMOs function primarily as marketing and facultative agencies and bear no risk for adverse experience. This type of HMO contracts with one or more IPAs and hospitals on a capitation basis, retaining a portion of the fee to cover marketing and administrative costs. In this situation, the adverse experience risk is borne by the IPAs and hospitals. This shifting of risk may be of short-term benefit to the HMO, since the hospitals, groups, or IPAs with adverse experience are likely to demand higher capitation fees or refuse to renew the contract.

A-19. By contractual agreement, the HMO may shift the burden of providing and paying for services to the medical group or IPA. In this situation, the HMO pays the medical group or IPA a capitation fee to provide a predetermined range of physician and other outpatient services. In the group and staff model HMOs, physician and other outpatient services are period expenses and are relatively fixed, because the physicians and medical-support personnel are salaried employees. Although the number of employees will vary with the level of enrollment, this variance is a step increment.

A-20. In the group or staff model HMO, incremental costs consist primarily of nonemployee specialized services that must be purchased (for

example, the services of a specialist in open heart surgery). In an IPA model, physician service costs will be fixed for the HMO if the IPA is compensated on a capitation basis. In this situation, incremental costs would be incurred only if services must be purchased from nonmember providers. Similarly, incremental costs generally are limited to costs incurred at nonmember facilities, such as out-of-area or emergency services, if an HMO owns its own hospital or compensates its member hospital on a capitation or other fixed basis. If member hospitals, IPAs, groups, or individual physicians are compensated on a fee-for-service basis, each service may be viewed as an incremental cost.

Comparison of HMOs and Insurance Companies

A-21. Both HMOs and insurance companies provide coverage for health care services. The fundamental difference between HMOs and insurance companies is that HMOs also undertake to provide, or arrange for the provision of, the covered health care services. In providing such services, the HMO exercises some control over the use of these services and frequently must approve coverage of certain services before they are provided. The insurance company provides an indemnity and does not have the ability to approve services or, therefore, to refuse a covered claim before the services are provided.

A-22. HMOs and insurance companies consider the following similar factors in determining the premium charged for coverage.

A-23. *Cost Assumption.* Premium rates are established by HMOs and insurance companies, for either a group or an individual policy, by projecting the anticipated costs of providing the health care services, expenses, and a margin for adverse experience. The projections include, in addition to anticipated price changes, estimates of hospital days, physician visits, outpatient services, maternity, and policyholder or member termination. Also included are estimates for extended care beyond the contract or policy period.

A-24. *Risk Assumption.* HMOs and insurance companies frequently differ in their risk-rating approach to setting premiums. Insurance companies aggregate claims experience and estimate experience ratings for each insured group. Federally qualified HMOs generally use community-rating methods based on geographic area or actuarial classes, whereas nonqualified HMOs may use individual-contract group ratings (experience-rating methods). As a result, federally qualified HMOs and HMOs that do not use contract group rating methods are susceptible to a greater risk of adverse experience than are insurance companies.

A-25. *Coverage Period and Payment Mode.* Premiums are typically set by HMOs and insurance companies for a contract period of one year and are

designed to cover the anticipated costs for that period. Some believe that HMOs differ from insurance companies in that the premiums cover the anticipated costs on a monthly basis. This is a somewhat artificial distinction because health care services show seasonal variations, and premiums are designed to cover health care costs over the contract term. Both insurance companies and HMOs experience seasonal variation in claims throughout the contract period.

A-26. HMOs and insurance companies recognize premium revenues in essentially the same manner. Premiums generally are paid on a monthly basis in advance. If the participant cancels coverage, the cancellation generally takes effect as of the last day of the month to which the last paid premium applies.

A-27. A policyholder or member may cancel an insurance policy or HMO contract at any time. Generally, cancellation may be made only by the insured, not by the HMO or insurance company. The insurance company or HMO is committed to provide coverage during the contract period as long as the premiums are paid and may not terminate coverage, even if they have had or will have adverse experience.

A-28. An insurance company is liable for coverage of an insured incident that occurs while the policy is in force, even though some of the costs related to the incident may be incurred after the policy is terminated. For an insurance company, extended coverage would include the following:

- Hospitalization and physician services directly related to the incident.
- Extended benefit provisions (typically included in major medical policies) for a limited duration, such as to the end of the calendar year in which the policy terminates plus one year, and may include maternity extensions. Many insurance companies are no longer offering this feature.
- Total disability and care incident to a specific occurrence, for which the duration of coverage is usually limited.

A-29. An HMO has an obligation to provide health care services during the premium period, provided the premiums are paid. Generally, the HMO does not have an obligation to provide services after a member has stopped premium payments, even though the accident or condition for which the member obtains health care occurred during the premium period. However, an obligation may extend beyond the premium period depending on the specific contract terms or federal or state regulation. Certain contracts provide for extension of coverage for specific items such as pregnancy. The HMO may have an obligation for extension of benefits to hospitalized participants, including not only hospital charges and related inpatient services, but also physician and referral fees through the date of discharge. The HMO, however, does not have an obligation for extended care beyond the period of hospitalization.

A-30. Under a group contract with an insurance company, it is likely that the employer, depending on its disability policy, will continue to pay premiums while the employee is disabled. Similarly, it is also reasonable to assume that an individual HMO member requiring continued health care will continue to pay premiums because the premium cost would be far less than the related health care costs. A member may not continue to pay premiums as a result of inability, ignorance, or incapacitation.

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